Crisis Bed Development Work Group

August 23, 2006 1:00 p.m. – 4:00 p.m.
Health Care and Rehabilitation Services of Southeastern Vermont (HCRS)
Alternatives – a crisis bed program of HCRS

Next meeting: September 13, 2006 1:00 – 3:00 p.m.

Location: Clara Martin Center, Randolph

Present:	Jeff Rothenberg, CMC Graham Parker, HCRS Sandy Smith, CSAC John Stewart, RMHS (by phone) Anne Donahue, Counterpoint (by phone)
Guest:	Michael O'Sullivan, Director, Alternatives
Staff:	Judy Rosenstreich, VDH/DMH Cindy Thomas, VDH/DMH (by phone)

Jeff, Sandy and Judy visited Alternatives to see the facility and talk with the staff. Michael O'Sullivan, director of Alternatives, provided not only a tour of the house but also substantial information on the program's philosophy, operations, and challenges.

Alternatives

The house is located outside of the village of Bellows Falls. It accommodates four residents with two single rooms and one double room. A staff of three-- Michael, the director, Mariah and Linda--provides 24-hour supervision, as follows:

- Night: 1 awake staff
  1 on-call staff that is in the house asleep

- Day: 1 Crisis Stabilization Specialist (CSS)
  1 Director, Michael O'Sullivan, R.N.

Michael described the program culture as different than a hyper-vigilant hospital setting. He remarked that safety stems from the relationships between staff and clients. There is no tolerance for destructive behavior. If a client is troubled by such thoughts, he/she should come to staff. In a rare instance of out-of-control behavior, the police are called. In other instances, the least restrictive means is used to deal with a situation.

The Windham Center may also help. It was downsized from 19 to 10 beds this year. Losing nine psychiatric beds in this region has a severe impact, according to Michael. They are full all of the time.

We have had to call police six times in our six years here. This limited reliance on the police reflects the quality of the staff. They are with the clients, know them, and pay attention so situations do not come out of the blue.

Jeff asked if a doctor oversees the program. Michael responded that this has been eroding over time, a function of the budget. He was clear that this is not his preference. Alternatives had the last visit today from a doctor who is retiring. Now we will have a doctor stopping by only to review and sign charts. We call HCRS when we need them. Each client has a psychiatrist of record. The agency (HCRS) doctors are good, however, any doctor is reluctant to prescribe medications to patients they have never seen.

HCRS has a police social worker, Glen Tirell. He intervenes in police matters that have a mental health component. His office is at the police station. Glen is a full-time employee of HCRS. He improves relationships through his understanding and by offering guidance on what the dispatcher wants / needs to hear. This role is a real plus for clients and the community.

Alternatives is JACHO approved.

The common area is a living and dining room plus the kitchen.

The gardens are nicely landscaped with flowers and trees.

The basement has a chart room and the director's office:

- Chart Room: Separate charts from the rest of the agency. It's just the chart relative to this program. People here average 5 to 7 days. Our mission is to keep stays brief.
- Director's Office: Michael's office has a bed for staff to sleep. Staff meetings are held here.

Jeff asked how helpful it is to have a nurse as head of the program. Michael shared his background: 13 years at the Retreat as a staff nurse on the floor; a nurse at HCRS dealing with clinical issues. He said that managing medications is an intensive piece of the work at Alternatives. We have a system of accounting for medications. We see people who are on more than 30 medications. The nursing component is an essential element.

Work Group Meeting at the Bellows Falls Health Center

Jeff began the meeting by stating his intentions of writing up a draft report based on the framework discussed at the July 28th work group meeting.
(1) What is needed for a transformed system?
(2) What are the gaps in the system?
(3) What are the priorities among the gaps?

He also let members know that he was invited to participate in a meeting with the Vermont Association of Hospitals and Health Systems (VAHHS) which Judy had set up. This meeting is to discuss the concept of community hospital involvement in providing statewide access to a crisis bed.

The group discussed the fact that some designated agencies may have proposals for crisis bed programs that they wish to present to the Mental Health Division. Jeff and others understood that the Crisis Beds Work Group was set up to undertake a statewide assessment of the need for crisis beds in terms of location, services, and programmatic characteristics. It is important that this process be completed with recommendations to the Futures Advisory Committee to provide the Division with a context within which to allocate resources.

Graham told the group about the building that HCRS owns in Springfield that was previously used for a children's crisis bed program. While renovations would be required, the facility is quite easily adaptable to a crisis bed program and is something his agency would like to pursue.

Jeff shared his impression that almost all of the agencies have indicated an interest in having some step-down facility.

Jeff observed that all four existing crisis bed programs have similarities as well as significant differences. He will make a list of what is the same and what is different about these programs for the group to consider. Jeff posed the question whether some differences reflect two different levels of care, a question for the care management system to answer.

The degree of standardization among crisis beds is an issue. Alternatives has RN's but the least psychiatric coverage. Home Intervention has a psychiatrist two hours a day. Battele has nurses on site and a doctor at the agency.

Another issue is whether the Futures program would consider using some of its available resources to augment an existing program in addition to developing new programs.

The group listed some of the issues about which it has gathered information, discussed with Emergency Services and CRT directors, and identified as part of the overall picture of an expanded capacity to prevent unnecessary hospital admissions:

1. standardization
2. connection to the care management system which, in turn, is connected to VSH, general hospitals, existing crisis beds, and other CMHC services
3. the group's goal:
    a. Providing access to 90% of Vermont residents within 30 minutes, and
    b. Providing access to 100% of Vermont residents within 1 hour.
4. cadre of peers in crisis facilities
5. more housing

6. in each community hospital a 72-hour triage / inebriate bed
7. transport issues all worked out
8. adequate funding for existing crisis services
9. secure triage and assessment facilities at all hospital emergency rooms

Cindy reminded the group of a report compiled by Patti Barlow in 2001, detailing different models for filling the gaps in crisis beds with associated costs of each. Judy will distribute this to the Crisis Bed Work Group.

Anne shared that she participated in Fletcher Allen's Quality Committee meeting and brought up the idea of hospital-based observation beds.

DUAL DIAGNOSIS

Jeff reported that he talked with Nick Nichols about the availability of crisis beds for individuals who are dually diagnosed. VDH/ADAP has asked if the beds are there, if staff is there, will the crisis bed program serve someone dually diagnosed? While crisis bed programs do serve such individuals, they do not take someone in an inebriated state.

Judy asked Michael O'Sullivan to comment on the issue from his perspective as the director of a crisis bed program. Michael stated that it is not medically safe and would be a liability to accept a client who is intoxicated without an RN present. Alternatives has an RN about 60 percent of the week. Michael explained that there are medical issues associated with intoxication. Anne agreed that for all the medical reasons Michael had cited, the Department of Corrections does not want people who are intoxicated dropped off.

PLANNING THE GROUP'S NEXT STEPS

Jeff engaged the group in discussion about how to go about prioritizing and recommending where in the State we should direct new resources. Part of the answer may rest with interest among the agencies to provide these services. Graham expressed interest on the part of HCRS to move forward fairly soon with redevelopment of their building in Springfield. It was understood that HCRS may write to the Division and copy Judy who will share the letter with the work group so we all can be informed about the possibilities statewide.

The group considered a possible timetable for bringing together its findings and recommendations.

September 13 Review a draft report at its next meeting.

October 16 Request time on the Advisory Committee agenda to present the report.

September Data Gathering by Emergency Services Directors

Jeff is asking the Emergency Services Directors to use September as the month to track people they are seeing who could have gone to a crisis bed program having these components:

- being voluntary in nature
- having awake staff at all times
- having a ration of 2 clients to 1 staff
- having 5 x a week psychiatrist on site
- having 8 hours of nursing per day
- being coordinated with your CRT program
- being within your agency's catchment area
- training of all staff in dual diagnosis with a solid knowledge of recovery principles
- having a LOS expectation of 7 days

These program components were in our original survey, however, the task involved looking *back* over six months of screenings. This request is prospective, asking the ES directors to imagine a program in their area having these components and, if they had the above, how many people they will see in September could go into a crisis bed.

Jeff shared a concern about the voice of Emergency Services Directors, uncertain whether they continue to have regular meetings or if their meetings are well attended.

Designated Hospitals

In concert with the meeting we have set up with VAHHS on observation beds in community hospitals, the group suggested that we ask Patti Barlow to put this topic on the agenda of the designated hospitals monthly meeting with DMH. Judy will follow up.

Judy thanked Michael O'Sullivan for taking us through his program at Alternatives and for participating in our meeting. She asked if he would like to comment on the issues before the work group. Michael offered that for him to run a cost-effective program, there needs to be some other level of beds, and that the need for supervised housing is very great. Often it's the case that homeless people are stuck in our crisis beds. Once they are stable, that is an opportune time for them to go into housing but often there is none. He welcomes other visitors to Alternatives.

The meeting adjourned at 4:00 p.m.

SUBMITTED BY: Judy Rosenstreich
jrosen@vdh.state.vt.us